

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0043695</u></p> <p>Facility Name: <u>WILLOW WOOD HEALTH CARE CENTER</u></p> <p>Address: <u>430 MARTIN ROAD, P.O. BOX 579</u> <u>ROCK FALLS</u> <u>61071</u> Number City Zip Code</p> <p>County: <u>WHITESIDE</u></p> <p>Telephone Number: <u>(815) 626-4575</u> Fax # <u>(815) 626-8264</u></p> <p>IDPA ID Number: <u>830320180028</u></p> <p>Date of Initial License for Current Owners: <u>02/07/98</u></p> <p>Type of Ownership:</p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>William H. Keys</u> Telephone Number: <u>(317) 208-2740</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table> <tr> <td data-bbox="1165 678 1297 824" rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Larry Bonds</u></td> </tr> <tr> <td data-bbox="1165 824 1297 1036" rowspan="4">Paid Preparer</td> <td>(Title) <u>President</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1165 1036 1297 1117" rowspan="2"></td> <td>(Telephone) _____ Fax # () _____</td> </tr> <tr> <td> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Larry Bonds</u>	Paid Preparer	(Title) <u>President</u>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) _____ Fax # () _____	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																		
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STATE OF ILLINOIS

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Facility Name & ID Number WILLOW WOOD HEALTH CARE CENTER# 0043695 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>0</u>	Skilled (SNF)	<u>0</u>	<u>0</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,805</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,805</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>0</u>	<u>0</u>	<u>0</u>		8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>10,547</u>	<u>4,590</u>	<u>0</u>	<u>15,137</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>10,547</u>	<u>4,590</u>		<u>15,137</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 72.76%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - NoneF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 02/07/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/07/98 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED ☐ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number WILLOW WOOD HEALTH CARE CENTE # 0043695 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,508	9,133	5,756	116,397		116,397		116,397		1
2	Food Purchase		101,813		101,813		101,813		101,813		2
3	Housekeeping	45,440	7,257		52,697		52,697		52,697		3
4	Laundry	25,591	10,650		36,241		36,241		36,241		4
5	Heat and Other Utilities			40,965	40,965		40,965	37	41,002		5
6	Maintenance	21,240	1,019	13,747	36,006		36,006	100	36,106		6
7	Other (specify):* Waste Removal			1,075	1,075		1,075		1,075		7
8	TOTAL General Services	193,779	129,872	61,543	385,194		385,194	137	385,331		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	424,105	17,192	7,911	449,208		449,208		449,208		10
10a	Therapy		8,803		8,803		8,803	4	8,807		10a
11	Activities	28,987	930	3,489	33,406		33,406		33,406		11
12	Social Services	27,302		3,239	30,541		30,541		30,541		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	480,394	26,925	14,639	521,958		521,958	4	521,962		16
	C. General Administration										
17	Administrative	30,388			30,388		30,388		30,388		17
18	Directors Fees										18
19	Professional Services			42,861	42,861		42,861	74,753	117,614		19
20	Dues, Fees, Subscriptions & Promotions			4,043	4,043		4,043	276	4,319		20
21	Clerical & General Office Expenses	57,601	30,307	85,094	173,002		173,002	26,174	199,176		21
22	Employee Benefits & Payroll Taxes			177,583	177,583		177,583	5	177,588		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,956	4,956		4,956	3,005	7,961		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,873	51,873		51,873	31,364	83,237		26
27	Other (specify):*										27
28	TOTAL General Administration	87,989	30,307	366,410	484,706		484,706	135,577	620,283		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	762,162	187,104	442,592	1,391,858		1,391,858	135,718	1,527,576		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			38,837	38,837		38,837		38,837			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			175,293	175,293		175,293	1,333	176,626			32
33	Real Estate Taxes			22,733	22,733		22,733	46	22,779			33
34	Rent-Facility & Grounds							1,525	1,525			34
35	Rent-Equipment & Vehicles			1,753	1,753		1,753	290	2,043			35
36	Other (specify):* See Attached			68,283	68,283		68,283	(49,893)	18,390			36
37	TOTAL Ownership			306,899	306,899		306,899	(46,699)	260,200			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			250	250		250		250			38
39	Ancillary Service Centers		2,269		2,269		2,269		2,269			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,473	38,473		38,473		38,473			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,269	38,723	40,992		40,992		40,992			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	762,162	189,373	788,214	1,739,749		1,739,749	89,019	1,828,768			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$ #VALUE!	#####	\$	1
2 Other Care for Outpatients	#VALUE!	#####		2
3 Governmental Sponsored Special Programs	#VALUE!	#####		3
4 Non-Patient Meals	#VALUE!	#####		4
5 Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6 Rented Facility Space	#VALUE!	#####		6
7 Sale of Supplies to Non-Patients	#VALUE!	#####		7
8 Laundry for Non-Patients	#VALUE!	#####		8
9 Non-Straightline Depreciation	#VALUE!	#####		9
10 Interest and Other Investment Income	#VALUE!	#####		10
11 Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12 Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13 Sales Tax	#VALUE!	#####		13
14 Non-Care Related Interest	#VALUE!	#####		14
15 Non-Care Related Owner's Transactions	#VALUE!	#####		15
16 Personal Expenses (Including Transportation)	#VALUE!	#####		16
17 Non-Care Related Fees	#VALUE!	#####		17
18 Fines and Penalties	#VALUE!	#####		18
19 Entertainment	#VALUE!	#####		19
20 Contributions	#VALUE!	#####		20
21 Owner or Key-Man Insurance	#VALUE!	#####		21
22 Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23 Malpractice Insurance for Individuals	#VALUE!	#####		23
24 Bad Debt	#VALUE!	#####		24
25 Fund Raising, Advertising and Promotional	#VALUE!	#####		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax	#VALUE!	#####		26
27 Nurse Aide Training for Non-Employees	#VALUE!	#####		27
28 Yellow Page Advertising	#VALUE!	#####		28
29 Other-Attach Schedule (See page 5a)	#VALUE!	#####		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ #VALUE!		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$ #VALUE!	#####	31
32 Donated Goods-Attach Schedule*	#VALUE!	#####	32
33 Amortization of Organization & Pre-Operating Expense	#VALUE!	#####	33
Adjustments for Related Organization			
34 Costs (Schedule VII)	#VALUE!	#####	34
35 Other- Attach Schedule	#VALUE!	#####	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ #VALUE!		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ #VALUE!		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39		X			39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
WILLOW WOOD HEALTH CARE CENTER

Page 5A

ID# 0043695
Report Period Beginning: 1/1/2001
Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	#VALUE!	\$ #VALUE!	#VALUE!	1
2	#VALUE!	#VALUE!	#VALUE!	2
3	#VALUE!	#VALUE!	#VALUE!	3
4	#VALUE!	#VALUE!	#VALUE!	4
5	#VALUE!	#VALUE!	#VALUE!	5
6	#VALUE!	#VALUE!	#VALUE!	6
7	#VALUE!	#VALUE!	#VALUE!	7
8	#VALUE!	#VALUE!	#VALUE!	8
9	#VALUE!	#VALUE!	#VALUE!	9
10	#VALUE!	#VALUE!	#VALUE!	10
11	#VALUE!	#VALUE!	#VALUE!	11
12	#VALUE!	#VALUE!	#VALUE!	12
13	#VALUE!	#VALUE!	#VALUE!	13
14	#VALUE!	#VALUE!	#VALUE!	14
15	#VALUE!	#VALUE!	#VALUE!	15
16	#VALUE!	#VALUE!	#VALUE!	16
17	#VALUE!	#VALUE!	#VALUE!	17
18	#VALUE!	#VALUE!	#VALUE!	18
19	#VALUE!	#VALUE!	#VALUE!	19
20	#VALUE!	#VALUE!	#VALUE!	20
21	#VALUE!	#VALUE!	#VALUE!	21
22	#VALUE!	#VALUE!	#VALUE!	22
23	#VALUE!	#VALUE!	#VALUE!	23
24	#VALUE!	#VALUE!	#VALUE!	24
25	#VALUE!	#VALUE!	#VALUE!	25
26				26
27	#VALUE!	#VALUE!	#VALUE!	27
28	#VALUE!	#VALUE!	#VALUE!	28
29	#VALUE!	#VALUE!	#VALUE!	29
30	Other - Goodwill	(68,283)	36	30
31				31
32	Vending revenue	(47)	21	32
33				33
34				34
35				35
36				36
37				37
38				38
39	Subtotal Line 29	(68,330)	#VALUE!	39
40			#VALUE!	40
41	#VALUE!	#VALUE!	#VALUE!	41
42	#VALUE!	#VALUE!	#VALUE!	42
43				43
44	#VALUE!	#VALUE!	#VALUE!	44
45				45
46	#VALUE!	#VALUE!	#VALUE!	46
47	#VALUE!	#VALUE!	#VALUE!	47
48				48
49	Total	#VALUE!		49

Summary A

0043695

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOW WOOD HEALTH CARE CENTER# 0043695

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,333	0	0	0	0	0	0	0	0	0	1,333	32
33	Real Estate Taxes	0	0	46	0	0	0	0	0	0	0	0	46	33
34	Rent-Facility & Grounds	0	0	1,525	0	0	0	0	0	0	0	0	1,525	34
35	Rent-Equipment & Vehicles	0	0	290	0	0	0	0	0	0	0	0	290	35
36	Other (specify):*	(68,283)	0	18,390	0	0	0	0	0	0	0	0	(49,893)	36
37	TOTAL Ownership	(68,283)	1,333	20,251	0	0	0	0	0	0	0	0	(46,699)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(68,330)	137,098	20,251	0	0	0	0	0	0	0	0	89,019	45

Facility Name & ID Number WILLOW WOOD HEALTH CARE CENTER # 0043695 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	2	Food Purchase	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$	1
2	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	37		2
3	V	6	Maintenance		Senior Living Properties, LLC	100.00%	100		3
4	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		4
5	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		5
6	V	10a	Therapy		Senior Living Properties, LLC	100.00%	4		6
7	V	19	Professional Services		Senior Living Properties, LLC	100.00%	74,753		7
8	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	276		8
9	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	26,221		9
10	V	22	Employee Benefits & Payroll Taxes		Senior Living Properties, LLC	100.00%	5		10
11	V	24	Travel and Seminar		Senior Living Properties, LLC	100.00%	3,005		11
12	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	31,364		12
13	V	32	Interest		Senior Living Properties, LLC	100.00%	1,333		13
14	Total			\$			\$ 137,098	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **WILLOW WOOD HEALTH CARE CENTER**# **0043695**Report Period Beginning: **1/1/2001**Ending: **12/31/2001****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger		Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
		Item	Amount	Name of Related Organization			
15	V	33	Real Estate Taxes	\$	100.00%	\$ 46	\$ 46
16	V	34	Rent-Facility & Grounds		100.00%	1,525	1,525
17	V	35	Rent-Equipment & Vehicles		100.00%	290	290
18	V	36	Loss, Goodwill, & Depreciation		100.00%	18,390	18,390
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 20,251	\$ * 20,251

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW WOOD HEALTH CARE CENTI # 0043695 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **WILLOW WOOD HEALTH CARE CENTER**# **0043695**Report Period Beginning: **1/1/2001**Ending: **2/31/2001****VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Senior Living Properties, LLC

Street Address

12400 N. Meridian Street, Suite 180

City / State / Zip Code

Carmel, Indiana 46032

Phone Number

(317) 208-2740

Fax Number

(317) 575-2562

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	See attachment	See attachment	See attachment	\$ 0	See attachment	\$ 0	1
2	5	Heat and Other Utilities	See attachment	See attachment	See attachment	2,029	See attachment	37	2
3	6	Maintenance	See attachment	See attachment	See attachment	10,713	See attachment	100	3
4	7	Waste Removal	See attachment	See attachment	See attachment	6	See attachment	0	4
5	10	Nursing & Medical Records	See attachment	See attachment	See attachment	0	See attachment	0	5
6	10a	Therapy	See attachment	See attachment	See attachment	452	See attachment	4	6
7	19	Professional Services	See attachment	See attachment	See attachment	7,709,475	See attachment	74,753	7
8	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	17,834	See attachment	276	8
9	21	Clerical & General Office Expenses	See attachment	See attachment	See attachment	2,749,973	See attachment	26,221	9
10	22	Employee Benefits & Payroll Taxes	See attachment	See attachment	See attachment	508	See attachment	5	10
11	24	Travel and Seminar	See attachment	See attachment	See attachment	837,931	See attachment	3,005	11
12	26	Insurance - Prop Liab Malpractice	See attachment	See attachment	See attachment	1,271,868	See attachment	31,364	12
13	32	Interest	See attachment	See attachment	See attachment	53,649	See attachment	1,333	13
14	33	Real Estate Taxes	See attachment	See attachment	See attachment	4,962	See attachment	46	14
15	34	Rent-Facility & Grounds	See attachment	See attachment	See attachment	162,698	See attachment	1,525	15
16	35	Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	31,048	See attachment	290	16
17	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	1,962,703	See attachment	18,390	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 14,815,849	\$		\$ 157,349	25

Facility Name & ID Number **WILLOW WOOD HEALTH CARE CENTE** # **0043695** Report Period Beginning: **1/1/2001** Ending: **12/31/2001**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC Comm Mort Corp		X	Acquisition	\$11,068.00	02/06/98	\$ 1,578,610	\$ 1,580,586	02/01/08	0.0681	\$ 115,027	1	
2	Complete Care Services		X	Acquisition	\$5,821.00	02/06/98	69,850	73,794	02/06/08	N/A - None	N/A - None	2	
3	Manager Note		X	Acquisition	\$5,821.00	02/06/98	69,850	73,794	02/06/08	N/A - None	N/A - None	3	
4												4	
5												5	
	Working Capital												
6	Line of Credit		X	Working Capital	None	02/06/98	Various	424,866	Demand	Prime + 2%	41,342	6	
7	Other Interest										20,257	7	
8												8	
9	TOTAL Facility Related				\$22,710.00		\$ 1,718,310	\$ 2,153,040			\$ 176,626	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,718,310	\$ 2,153,040			\$ 176,626	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																						
1. Real Estate Tax accrual used on 2000 report.		\$ 50,373	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 50,373	2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	3																			
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 22,733	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 22,733	7																			
Real Estate Tax History:																						
Real Estate Tax Bill for Calendar Year:	1996 29,136 8 1997 44,038 9 1998 23,191 10 1999 22,432 11 2000 50,373 12	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																						
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13																			
14	PLUS APPEAL COST FROM LINE 5	\$	14																			
15	LESS REFUND FROM LINE 6	\$	15																			
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																			

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLOW WOOD HEALTH CARE CENTER COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0043695

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317) 581-9513

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>11-27-427-006</u>	<u>See Attached</u>	<u>\$ 22,177.86</u>	<u>\$ 22,177.86</u>
2.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
3.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
4.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
5.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
6.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
7.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
8.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
9.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
10.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
		TOTALS	\$ <u>22,177.86</u>	\$ <u>22,177.86</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

12,658

B. General Construction Type:

Exterior

MASONRY

Frame

MASONRY

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	49,223	1998	\$ 13,454	1
2					2
3	TOTALS	49,223		\$ 13,454	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	57	1998	1972	\$ 550,506	\$ 18,350	30	\$ 18,350	\$ 0	\$ 71,871
5						-			
6						-			
7						-			
8						-			
Improvement Type**									
9	replace water	1998		1,338	134	10	134	(0)	435
10	walkway cover	1998		2,284	152	15	152	0	469
11	storage shed	1998		2,376	238	10	238	(0)	753
12	water heater	1998		2,784	278	10	278	0	928
13	sewer pipe	1998		3,850	193	20	193	(1)	722
14	floor burnished	1998		2,418	484	5	484	(0)	1,532
15	signage	1998		464	46	10	46	0	166
16	land improvement	1998		5,614	374	15	374	0	1,466
17	reroute water line	1999		695	28	25	28	(0)	67
18	main pipe	1999		1,390	56	25	56	(0)	125
19	seal	1999		1,000	200	5	200		567
20	landscaping	1999		2,649	265	10	265	(0)	640
21	water line	2000		1,095	156	7	156	0	169
22	boilers	2000		7,125	1,018	7	1,018	(0)	1,005
23	air compressor for sprinkler system	2000		2,148	143	15	143	0	191
24						-			
25	boilers/water heater	2001		2,375	79	20	79		79
26						-			
27						-			
28						-			
29						-			
30						-			
31						-			
32						-			
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number **WILLOW WOOD HEALTH CARE CENTER**

STATE OF ILLINOIS

0043695

Report Period Beginning:

1/1/2001

Ending:

Page 12A

12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$	-	\$	\$		37
38					-				38
39					-				39
40					-				40
41					-				41
42					-				42
43					-				43
44					-				44
45					-				45
46					-				46
47					-				47
48					-				48
49					-				49
50					-				50
51					-				51
52					-				52
53					-				53
54					-				54
55					-				55
56					-				56
57					-				57
58					-				58
59					-				59
60					-				60
61					-				61
62					-				62
63	(DON'T ENTER BELOW THIS LINE)				-				63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 590,111	\$ 22,194		\$ 22,194	\$ (0)	\$ 81,185	70

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 118,955	\$ 15,930	\$ 15,930	\$	Various	\$ 59,051	71
72	Current Year Purchases	4,752	713	713		Various	713	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 123,707	\$ 16,643	\$ 16,643	\$		\$ 59,764	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			-	\$	\$	\$	\$		\$	76
77			-							77
78			-							78
79			-							79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 727,272	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,837	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 38,837	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 140,949	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,753 Description: Central Supply - 563, Dietary - 441, Plant - 470, Housekeeping - 159, Laundry - 119, Administrative - 1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Training was not necessary for aides, as the facility only hired aides who were already trained. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a, 3	hrs	\$	-	\$ -
2	Licensed Speech and Language Development Therapist		hrs		-	-	-				2
3	Licensed Recreational Therapist	10a, 3	hrs		-	-	8,472		8,472		3
4	Licensed Physical Therapist	10a, 3	hrs		-	-	20		20		4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts		-	-	-				9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$ 8,803		\$ 8,803		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 28,036	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	142,046		3
4	Supply Inventory (priced at)	4,019		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 174,101	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	13,454		13
14	Buildings, at Historical Cost	579,616		14
15	Leasehold Improvements, at Historical Cost	9,727		15
16	Equipment, at Historical Cost	124,475		16
17	Accumulated Depreciation (book methods)	(140,949)		17
18	Deferred Charges	785,113		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Rec / (Pay)</u>	(306,679)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,064,757	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,238,858	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,421	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,604		28
29	Short-Term Notes Payable	209,918		29
30	Accrued Salaries Payable	91,978		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other accrued expenses</u>	(45,695)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 376,226	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,694,177		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,694,177	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,070,403	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (831,545)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,238,858	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (768,659)	1
2	Restatements (describe):		2
3	Restatements of Prior Year to allow rollforward	523,500	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (245,159)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(586,386)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (586,386)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (831,545)	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number WILLOW WOOD HEALTH CARE CENTER # 0043695 Report Period Beginning: 1/1/2001

Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,388,285	1
2	Discounts and Allowances for all Levels	(235,562)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,152,723	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	568	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	129	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 697	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	(104)	28
28a	Vending	47	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (57)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,153,363	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	385,194	31
32	Health Care	521,958	32
33	General Administration	484,706	33
B. Capital Expense			
34	Ownership	306,899	34
C. Ancillary Expense			
35	Special Cost Centers	2,519	35
36	Provider Participation Fee	38,473	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,739,749	40
41	Income before Income Taxes (line 30 minus line 40)**	(586,386)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (586,386)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **WILLOW WOOD HEALTH CARE CENTER**# **0043695**Report Period Beginning: **1/1/2001**Ending: **12/31/2001****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,318	2,405	\$ 39,153	\$ 16.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,954	6,029	86,902	14.41	3
4	Licensed Practical Nurses	12,713	13,247	152,942	11.55	4
5	Nurse Aides & Orderlies	16,885	17,759	144,630	8.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,230	1,345	11,232	8.35	9
10	Activity Assistants	1,950	2,007	17,755	8.85	10
11	Social Service Workers	2,721	2,843	27,302	9.60	11
12	Dietician	2,861	2,861	19,943	6.97	12
13	Food Service Supervisor	1,401	1,459	17,919	12.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,260	9,513	63,646	6.69	15
16	Dishwashers					16
17	Maintenance Workers	2,743	2,839	21,240	7.48	17
18	Housekeepers	7,558	7,846	45,440	5.79	18
19	Laundry	3,439	3,531	25,591	7.25	19
20	Administrator	1,365	1,447	30,134	20.82	20
21	Assistant Administrator	46	46	254	5.53	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,330	4,748	57,601	12.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	34	34	477	14.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	76,808	79,959	\$ 762,162 *	\$ 9.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,713	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	48	\$ 2,713		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	195	\$ 7,001	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	195	\$ 7,001		53

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Sandra Scott	Admin.	0%	\$ 30,388	Workers' Compensation Insurance		\$ 21,160	IDPH License Fee		\$		
				Unemployment Compensation Insurance		-	Advertising: Employee Recruitment		4,133		
				FICA Taxes		69,725	Health Care Worker Background Check (Indicate # of checks performed <u>12</u>)				
				Employee Health Insurance		87,216					
				Employee Meals							
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		164		
				Other Benefits		(395)	Advertising & Public Relations		(254)		
						-					
				Employee Physicals		(123)					
				Home Office Allocation		5	Home Office Allocation		276		
							Less: Public Relations Expense				
							Non-allowable advertising		#VALUE!		
							Yellow page advertising		#VALUE!		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 30,388				TOTAL (agree to Sch. V, line 20, col. 8)		\$ #VALUE!		
B. Administrative - Other											
Description			Amount								
N/A			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$								
C. Professional Services											
Vendor/Payee	Type		Amount	Description		Line #	Amount	Description		Amount	
Legal Fees	Various		\$ 2,319	N/A			\$	Out-of-State Travel		\$	
Patient Litigation	Various		31,455								
Payroll Processing	Various		4,318								
Accounting	Various							In-State Travel		4,642	
EDP Services	Various		4,769								
								Seminar Expense		182	
								Business Meals		132	
								Home Office Allocation		3,005	
								Less: Entertainment Expense		#VALUE!	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 42,861	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ #VALUE!	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number **WILLOW WOOD HEALTH CARE CENTER**

STATE OF ILLINOIS

0043695

Report Period Beginning: **1/1/2001**

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,293 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 38,473
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 568
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.